Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Experiences of Managed Care and SUD Provider Organizations with Changes in Patient Placement Criteria and Utilization Management

May 2025

RTI International

Introduction

Drug overdose is the leading cause of injury death in America, and opioids were involved in 75 percent of overdose deaths in 2020.[1] Factors contributing to the high number of overdose deaths include low rates of treatment for substance use disorder (SUD),[2] the stigma associated with seeking treatment,[3] and a shortage of health care professionals to treat SUD.[4] Medicaid beneficiaries face additional barriers to finding a treatment setting that meets their needs because of low participation in Medicaid by SUD treatment facilities.[5] Moreover, many SUD services are an optional benefit in Medicaid, and most states historically have not covered the full continuum of SUD services. Through section 1115 demonstrations, the Centers for Medicare & Medicaid Services (CMS) is partnering with states to test means of increasing access to the full continuum of care for SUD, including medication-assisted treatment (MAT) and residential treatment, as advocated by leading treatment addiction experts.[6,7,8]

This report is part of a series of rapid cycle reports intended to share findings and insights about section 1115 SUD demonstrations. This report summarizes the experiences of managed care and SUD provider organizations in 10 states implementing changes to achieve the demonstration milestone of widespread use of evidence-based, SUD-specific patient placement criteria.

Specifically, this report addresses the following three research questions:

1. What changes did managed care and SUD provider organizations make to implement patient placement criteria and utilization management (UM) under the section 1115 demonstrations?
2. What challenges did these organizations experience implementing these changes?
3. What are the perceived effects of these changes on beneficiary access to treatment, engagement in treatment, and retention in treatment, including health equity?

Understanding the changes states, Medicaid managed care organizations (MCOs), and providers made to meet demonstration requirements and the challenges they experienced in implementation will inform the meta-evaluation of section 1115 SUD demonstrations to be conducted and interpretation of observed demonstration impacts on key outcomes across states.

About Section 1115 SUD Demonstrations

The goals of section 1115 SUD demonstrations include increasing access to SUD treatment and raising rates of identification, initiation, and engagement in treatment; increasing treatment adherence and retention; reducing overdose mortality; decreasing preventable or

[1] Centers for Disease Control and Prevention (CDC). (2024). *Understanding the opioid overdose epidemic*. https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html

[2] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. HHS Publication No. PEP20-07-01-001, NSDUH Series H-55. Rockville, MD: SAMHSA, Center for Behavioral Health Statistics and Quality. https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

[3] Cheetham A., Picco L., Barnett A., Lubman D.I., & Nielsen S. (2022). The impact of stigma on people with opioid use disorder, opioid treatment, and policy. *Substance Abuse Rehabilitation, 13*, 1-12. doi: 10.2147/SAR.S304566.

[4] Jones, C. M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health, 105*(8), e55–e63.

[5] MACPAC. (2018). *Access to substance use disorder treatment in Medicaid*. Chapter 4 in 2017 Report to Congress (June). MACPAC: Washington, DC.

[6] Centers for Medicare and Medicaid Services (CMS). (2015). *SMD # 15-003: New service delivery opportunities for individuals with a substance use disorder*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf

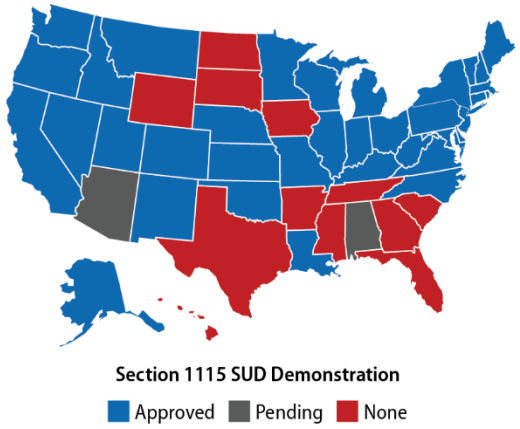
[7] CMS. (2017). *SMD # 17-003: Strategies to address the opioid epidemic*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[8] CMS, SAMHSA, & National Institutes of Health. (2014). *Joint informational bulletin: Medication assisted treatment for substance use disorders*. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf

inappropriate emergency department and inpatient hospital utilization; reducing preventable or inappropriate readmissions to the same or higher level of care (LOC); and improving access to care for physical health conditions.

As of February 2024, 36 states and the District of Columbia had received approval for section 1115 SUD demonstrations; 2 other states had pending applications (**Figure 1**).

Figure 1. Section 1115 SUD demonstration status as of February 2024



Generally, to receive approval for a section 1115 SUD demonstration, states must outline their plans for expanding access to multiple levels of evidence-based care and explain how inpatient and residential SUD services will coordinate with community-based recovery services. In return, states with approved section 1115 SUD demonstrations can receive federal financial participation (FFP) for SUD treatment services provided in residential and inpatient facilities that qualify as institutions for mental diseases (IMDs). These demonstrations generally require the state to submit and carry out implementation plans that set forth how the state will reach the following six milestones:

1. Access to critical levels of care for opioid use disorder (OUD) and other SUDs.
2. Widespread use of evidence-based, SUD-specific patient placement criteria.
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications, including implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.
4. Sufficient provider capacity at each level of care.
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
6. Improved care coordination and transitions between levels of care.

Overview of Findings

Demonstration Milestone 2—widespread use of evidence-based, SUD-specific patient placement criteria—requires providers to conduct a patient placement assessment using an evidence-based tool and MCOs to implement a utilization management (UM) approach that ensures patients have access to appropriate LOCs. Prior to the section 1115 SUD demonstrations, most MCO and provider respondents in the 10 states in which we conducted interviews had experience with patient placement criteria and UM. Many MCO and provider respondents across the states reported that they did not make changes to meet this demonstration milestone because these organizations had patient placement criteria or UM processes in place before the demonstrations began. Some respondents did make changes to meet new requirements, and these included:

- MCOs and provider organizations increased communication with providers to inform them about the patient placement criteria and new UM processes and offered training to help providers integrate these processes in their practices.
- MCOs made administrative changes to implement UM, which included developing authorization forms, utilization review (UR) processes, and, for some MCOs, moving UM in-house.
- MCOs and provider organizations hired new staff. New MCO staff were responsible for approving prior authorizations, conducting beneficiary care reviews, and instituting UM processes. New provider staff conducted patient placement assessments and communicated with the MCOs about prior authorization and UR.

Several factors created barriers for MCOs and provider organizations implementing patient placement criteria and UM:

- Conducting the patient placement assessment during patient visits was time intensive for providers and beneficiaries.
- Provider respondents described the requirement to use the patient placement criteria as diminishing their ability to exercise clinical judgement in assessing their patients' care needs.
- UM processes were burdensome for some MCOs and providers. MCO respondents highlighted that developing and implementing UM processes was time and resource intensive. Provider respondents found completing assessment paperwork, obtaining authorizations, and communicating with MCOs about prior authorization decisions were time intensive. These new tasks for MCO and provider organizations diverted resources from other activities and, in some cases, required hiring new staff.

- During the COVID-19 pandemic, MCOs lacked data required to monitor beneficiary care because nearly all states temporarily waived their UR and prior authorization requirements. However, provider respondents shared that this waiver gave them more clinical autonomy because they did not have to justify their treatment decisions to the MCOs or respond to UR requests.

Nearly all MCO and provider respondents in states that already used evidence-based, SUD-specific patient placement assessment reported no impact on beneficiaries' access to and engagement in treatment, but respondents in states where changes were made shared the following perceived impacts on beneficiaries:

- Provider respondents indicated that the time spent completing beneficiaries' assessments and the UM processes delayed beneficiaries' access to care and treatment.
- Provider respondents highlighted that the patient assessment tool supported providers' discussions with beneficiaries about treatment recommendations.
- MCO respondents shared perceptions that increased awareness of provider availability and treatment options led to improvements in beneficiaries' care access and quality.

Approach

Findings in this report are based on 70 interviews conducted by RTI International between June and October 2022 in 10 states with section 1115 SUD demonstrations. These states were Idaho, Kentucky, Michigan, Massachusetts, New Jersey, New Mexico, North Carolina, Virginia, West Virginia, and the District of Columbia.[9] Selected states had at least two years of demonstration experience as of July 2022, and expanded or added coverage for residential care for SUD and/or added or updated their patient placement criteria or policies related to care coordination under the demonstrations. Across these states, we interviewed 33 representatives from organizations contracted to manage a Medicaid population (i.e., MCOs and accountable care organizations) and other organizations responsible for managing SUD provider networks or access to SUD services for Medicaid beneficiaries (e.g., prepaid inpatient health plans [PIHPs]). Throughout this report, we refer to these representatives as "MCO respondents." We also interviewed 37 representatives from several types of provider organizations serving Medicaid beneficiaries, including residential service providers, nonresidential service providers, and providers offering both residential and nonresidential services. We refer to these representatives as "provider respondents." During the interviews, we asked MCO and provider respondents about the use of patient placement criteria to assess the appropriate LOC for beneficiaries and to describe UM approaches to ensuring and monitoring the delivery of appropriate care. **Appendix A** provides more information about the data collection methods used.

Results

Milestone 2 for the section 1115 SUD demonstrations guided states to implement policies that encourage widespread use of evidence-based, SUD-specific patient placement criteria. This milestone entailed providers using a multidimensional patient placement assessment tool to determine beneficiary treatment needs and MCOs implementing a UM approach "such that a) beneficiaries have access to SUD services at the appropriate LOC, b) interventions are appropriate for the diagnosis and LOC, and c) there is an independent process for reviewing placement in residential treatment settings."[10] Patient placement and UM are interrelated processes. Patient placement criteria inform the appropriate level of treatment for a patient. UM entails providers obtaining authorization from the MCO prior to providing treatment to a beneficiary with SUD (prior authorization). It also involves obtaining approval for continued stays in a residential facility or continued outpatient treatment, a component of utilization review (UR). UM processes ultimately determine whether and how much providers are paid, and what LOC patients can receive and for how long.[11]

Table 1 summarizes the patient placement criteria and UM changes the case study states made under their section 1115 SUD demonstrations. In many states, providers had used patient assessment tools for SUD services before the start of the demonstrations. Three states already required providers to use evidence-based, SUD-specific patient placement criteria to assess beneficiaries' care needs and made no changes to their requirements under the demonstrations. Four states required providers to use patient placement criteria prior to the demonstrations but updated their approach and requirements around these criteria because of the demonstrations. Many of these states required providers to use the American Society for Addiction Medicine's (ASAM) assessment tool,[12] an evidence-based patient placement assessment tool. One state, where providers used the GAIN-I tool[13] before the demonstration, updated their patient placement assessment process by switching to the ASAM tool for adult assessments as part of the demonstration. Only 3 of the

[9] For brevity, we refer to states and the District of Columbia as "states."
[10] CMS. (2017, November). *SMD#17-003, Strategies to address the opioid epidemic*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf
[11] Buck, J.A., & Silverman, H.A. (1996). Use of utilization management methods in state Medicaid programs. *Health Care Finance Rev, 17*(4), 77-86.
[12] For more information on the ASAM assessment tool, visit https://www.asam.org/asam-criteria/about-the-asam-criteria
[13] For more information on the GAIN-I assessment tool, visit https://gaincc.org/about/

10 states—New Mexico, Virginia, and West Virginia—added a new requirement to use patient placement criteria to determine LOC for beneficiaries with SUD.

Eight states had UM requirements in place before their demonstrations, and six of these states expanded their requirements under the demonstrations by including additional care settings or changing the parties involved in the UM process. For example, one state moved their UR process from the Medicaid agency to an external contract with a quality improvement organization. Two states—Massachusetts and Virginia—added new UM requirements and processes under the demonstrations.

Table 1. New or updated patient placement criteria and utilization management under section 1115 SUD demonstrations

State	Patient Placement Criteria	Utilization Management	State	Patient Placement Criteria	Utilization Management
District of Columbia	⊖	↗↙	New Jersey	⊖	⊖
Idaho	↗↙	↗↙	New Mexico	⊕	↗↙
Kentucky	↗↙	⊖	North Carolina	↗↙	↗↙
Massachusetts	⊖	⊕	Virginia	⊕	⊕
Michigan	↗↙	↗↙	West Virginia	⊕	↗↙

⊖ Requirements/processes in place prior to demonstration ↗↙ Updated/expanded requirements/processes ⊕ Added new requirements/processes

The sections that follow describe (1) MCO and provider changes in use of patient placement criteria and UM, (2) challenges MCOs and providers experienced, and (3) perceived impacts of the changes on beneficiaries' access to and engagement in care.

MCO and Provider Changes in Response to Patient Placement and Utilization Management Requirements

MCO and provider respondents in many states indicated that their patient placement criteria and UM processes did not change because they were well-established before the demonstrations began. One MCO respondent indicated, "The truth of the matter is we've always done ASAM…we've always had our treatment plans oriented to the six dimensions [of the] ASAM criteria."[14]

In states where changes were necessary to achieve the milestone's requirements, some MCO and provider respondents described making minimal adjustments to their patient placement and UM processes. In this section, we report the most common changes made by MCOs and providers to meet Milestone 2 under the demonstrations.

MCO changes

Provider education and communication. MCO respondents in most states reported that educating providers about patient placement and UM aimed to help providers understand the new processes and expectations and gain their buy-in. Even states that already had patient placement criteria and UM in place before their demonstrations used provider education to help implement Milestone 2. One MCO respondent stated, *"The education, the outreach is probably the area that we get the most positive feedback from providers on. [It] makes them feel supported, even with things such as we want them to have some sort of ASAM competency."*

Provider education came in many forms: virtual trainings, in-person orientations, one-on-one provider outreach and individualized technical assistance, and written information disseminated through reports, newsletters and other electronic means, such as provider bulletins. Some MCOs used multiple channels to educate providers. For example, one MCO respondent complemented their virtual trainings with written materials for providers such as a practice test on the assessment tool that was designed to help providers implement the patient placement criteria. Training topics usually included how to determine and document medical necessity, how to request prior authorization for services to ensure reimbursement for relevant services, and what UM entails. In some cases, states led trainings on patient placement requirements, which were attended by providers and MCO staff together.

MCO respondents in many states also described increasing communication with providers as an education strategy. MCOs used several strategies to increase communication with providers. One MCO respondent described having a dedicated SUD UR clinician that reviewed and communicated with all in-state residential treatment providers. Another MCO respondent described increasing the number of "huddles" (short group meetings with providers) to communicate changes in their UM process; huddles connected the MCO's UR

> *"You have the communications and training. You make available what criteria you're using, what is needed, also make it very easy for them to understand what's needed or required when they submit requests for clinical authorization."*
> -MCO respondent

[14] The ASAM Criteria use six dimensions to assess an individual's service planning and treatment needs: (1) acute intoxication and withdrawal potential; (2) biomedical conditions and complications; (3) mental health history and current mental health needs; (4) readiness to change; (5) unique needs that influence risk to relapse; and (6) living situation and housing needs.

team with provider staff who were responsible for the UM paperwork. MCO communications tended to focus on consistently applying the patient placement criteria, and guidance on navigating the prior authorization and other UM processes. Additionally, some MCO respondents in a few states shared that they increased communication with other MCOs in the state to ensure consistent UM-related information was disseminated to providers.

Administrative changes. MCO respondents in a few states reported establishing new processes to administer UM for beneficiaries with SUD. Two states did not require UM prior to their demonstrations and MCOs in those states had to start their UM processes from scratch. MCOs that implemented UM for the first time as a result of the demonstration developed standard operating procedures, forms, and data systems to collect and communicate UM-related information with providers and among MCO staff. One MCO respondent explained that they used experiences, insights, and resources from their national organization to build a UM structure that was modeled after UM programs in other states.

Some MCOs in a few states contracted with behavioral health vendors to conduct UM prior to the demonstrations; some of these MCOs moved their UM processes in-house as a result of their demonstrations. MCO respondents described several benefits of in-house UM, including greater ability to audit care. One MCO respondent highlighted that transitioning their UM system in-house provided insight into the day-to-day operations of providers and better understanding of beneficiaries' needs.

Many MCO respondents in many states already operated UM internally prior to the demonstrations and enhanced their UM processes by modifying prior authorization forms to better align with their assessment tool. Although many MCOs had experience conducting UM, several MCO respondents noted that the demonstration requirements led to an increased organizational focus on medical necessity and required staff to spend more time meeting with the MCOs' medical directors for case reviews.

Increased staff. MCO respondents in a few states reported hiring additional staff to conduct beneficiary care reviews, process prior authorizations, or answer UM-related questions. For example, some MCOs hired UR clinicians who acted as providers' primary contact with the MCO. One MCO respondent hired an additional psychologist to complete clinical peer reviews of prior authorization requests to ensure treatments or services requested were medically necessary for beneficiaries. MCOs had to train many of the newly hired staff on their state's new patient assessment tool.

Provider changes

Provider respondents described two areas of explicit change during the interviews—provider education and staffing increases. As described below, these mirror MCO changes.

Provider education. Providers attended trainings to understand the patient placement criteria, integration of the assessment tool in patient visits, and UM changes. Provider organizations conducted trainings for their staff, which often focused on how to use the patient assessment tool. In addition to trainings, providers received new guidance for identifying the medically necessary LOC.

> *"We are required to have all our licensed clinicians trained on ASAM and making sure that they understand the levels of care and how to make sure that they're putting or placing somebody in the appropriate level of care and providing the documentation if there isn't a higher level of care available. So we did have to do some additional trainings [for ASAM]…"*
> -Provider respondent

Increased staff. Provider respondents in many states commented that the new UM processes required that they hire staff. Typically, new staff were billing administrators to manage appeals and denials, and clinicians dedicated to UM. The implementation of patient placement criteria also required providers to invest in new staff to conduct the patient placement assessments. A few states had minimum education or certification requirements for staff conducting assessments, which limited providers' ability to hire these staff.

Challenges

Patient placement criteria

Time-intensiveness of the SUD-specific, multidimensional assessment tools. MCO and provider respondents from many states noted the significant time required to complete the assessment during a beneficiary appointment, which reduced the time available for clinical care. One provider respondent stated that using their state's selected tool added an hour to the time required to assess each beneficiary compared to their previous process. One MCO respondent noted that it can be especially challenging for providers to complete a lengthy assessment with beneficiaries who are under the influence of substances at the time of the appointment. Also, the amount of time required to complete the assessment was greater if the beneficiary was a polysubstance user. A provider respondent elaborated,

> *"If a client has more than one drug of choice, that makes the ASAM much, much longer. You're pretty much asking the same questions, but you're asking about that particular drug of choice. So that is very cumbersome…. So if you have a person that has multiple drugs of choice, and that's not mentioning the mental illness on top of that, it's extremely long and [patients] get frustrated."*

Providers and MCOs—in coordination with state Medicaid agencies—made or are considering several changes to address concerns related to the time-intensiveness of using an assessment tool. In one state, provider respondents discussed the potential for adopting a

"Treat First" model of care, under which beneficiaries can enter initial treatment before completing the full assessment. One provider respondent explained, *"We have talked a lot about using that [Treat First] model with the ASAM… so that patients feel as if they are getting some help right away, and that they don't have to fill out 47 pages of questionnaires before they can talk to someone about their problem."*

Similarly, an MCO respondent in another state explained that providers do not need to complete the full assessment to initiate treatment. Beneficiaries can begin treatment following a basic assessment, and providers are given additional time to complete the comprehensive assessment. Provider and MCO respondents also shared that integrating the assessment tool into their electronic health records facilitated its use by streamlining the client intake and assessment process. Additionally, despite concerns about the length of the ASAM assessment tool, in particular, provider respondents in a few states mentioned that it required less time and was easier to use than those used previously.

Tension between patient placement process and providers' clinical judgement. Provider respondents in some states explained that outcomes from the assessment tool did not always align with the care that they deemed most appropriate and limited their ability to exercise clinical judgement in treatment decisions. Specifically, provider respondents expressed concerns that these tools do not fully take into account "whole person" dimensions of beneficiary needs such as health-related social needs (HRSNs), comorbidities, and previous treatment history.[15] Additionally, some provider respondents described how the formulaic assessment interfered with their ability to use their clinical skills when caring for beneficiaries.

> *"[ASAM] really hampers our ability to use our clinical skills, because we have to make sure that we're checking boxes so that we complete the mandated thing… it makes it hard and can suck some of the joy out of why we do what we wanted to do and why we got this degree."*
> -Provider respondent

MCO respondents noted that resistance to adopting a patient assessment tool was higher among providers who had not been using one before the demonstration. Provider respondents who had previously used the ASAM tool (or a similar patient assessment tool) reported fewer challenges.

Interpretation of patient placement criteria by MCOs. Some provider respondents in half of the states explained that MCOs had different interpretations of the criteria for determining LOC. Because interpretation of the patient placement criteria affects treatment authorization and subsequent reimbursement, inconsistencies across MCOs frustrated provider respondents. One provider respondent summarized,

> *"I wish that there was standardized ASAM expectations, [but] every single payer interprets ASAM differently. And some of them are transparent about how they do it, and some of them are not."* Similarly, another provider respondent noted, *"The interpretation of the tool from the MCOs is different, depending on the MCO you talk to. They have their own set of people who interpret it and based on their interpretation, they will govern the authorizations as they see fit."*

This variation created confusion for providers, who had to meet different criteria depending on the MCO. Some provider respondents stated that MCOs' varying interpretations hindered their ability to standardize and streamline internal processes. In one state, MCOs worked with the state to develop consistency in their interpretation of assessment tool criteria.

Utilization management

Administrative burden of UM implementation. MCO and provider respondents from half the states described increased administrative burden arising from UM implementation, primarily because of the additional communication and paperwork related to medical necessity determinations. MCO respondents from some states described increased administrative burden related to contacting provider staff for medical necessity paperwork and justification. Similarly, provider respondents—some of whom were new to UM—noted that it was challenging to devote extensive time to communicating with MCOs about prior authorization decisions.

A few provider respondents mentioned that having to obtain authorizations from multiple MCOs was extremely challenging because the MCOs used different authorization forms, which further increased administrative and training burden for providers. In three states, MCOs developed a standard prior authorization template in response to provider concerns. One MCO respondent noted that these standardized forms significantly reduced service denials and sped up approvals, though some provider burden and authorization delays and denials persisted.

> *"And the other thing that the MCOs did that was helpful to the providers was that we all agreed to use the same authorization forms so that providers weren't trying to authorize services six different ways among six different MCOs. There's a lot of collaboration to make the process easier for providers who weren't familiar with managed care."*
> -MCO respondent

Some MCO and provider respondents also described the cost of hiring new staff to manage the UM process. As one provider respondent explained,

> *"My biggest concern and just my biggest gripe is that we are considering onboarding a utilization clinician that will just be dedicated to doing UM. We'll be planning on onboarding a biller, just focusing on billing and managing appeals and denials. So*

[15] Although the ASAM dimensions do include "unique needs that influence risk to relapse," provider respondents indicated that this dimension was not adequate for assessing the complex needs of beneficiaries with SUD.

that is an extra $150-200,000 a year to onboard two people to do that, counting benefits and everything. We have to pay money out in order to compete, catch up, stay on top of these arduous processes that health plans have."

Another provider respondent noted that it was challenging to hire staff to handle UM billing because few candidates want to process and review claims. An MCO respondent noted that smaller provider practices may not have sufficient staff to oversee the authorization request process. In contrast, larger practices can more easily reallocate resources to facilitate UM implementation. Most MCO and provider respondents also noted that provider training addressed some UM administrative challenges. Trainings typically covered medical necessity and the UM process.

Waiver of prior authorization requirements during the COVID-19 pandemic. During the COVID-19 public health emergency, CMS and some states temporarily waived prior authorization requirements for certain services. Forty-three states—including all 10 states in this analysis—received approval from CMS to suspend prior authorization for their fee-for-service Medicaid populations, and 5 of the states included in this analysis (KY, MA, NC, NJ, WV) waived prior authorization requirements through state administrative actions.[16] Additionally, CMS issued a blanket waiver of the requirement that hospitals have a UR plan with a committee to evaluate medical necessity of admissions, duration of stay, and services provided.[17] Collectively, these waivers allowed providers to offer clinical care without obtaining prior authorization. Some MCO respondents said the waivers presented challenges because they reduced the information MCOs received about their beneficiary population and limited their ability to oversee care use. One MCO respondent explained that they did not know when beneficiaries were admitted to or discharged from residential care, which made it difficult to support discharge planning and manage resources.

In contrast, some provider respondents welcomed the waivers and noted that they increased providers' autonomy and ability to make decisions based on their clinical judgement. One provider respondent expressed concern that the waivers were being lifted prematurely. Another voiced support for extension of the waivers and explained, *"We've shown it through the pandemic that providers can be trusted to treat patients and do the right thing for them, and we need to be allowed to continue to do that."*

Perceived Impacts of Changes in Patient Placement Criteria and Utilization Management on Beneficiaries' Access to, Engagement in, and Retention in Treatment

Nearly all MCO and provider respondents in states that already used SUD-specific patient placement assessments reported no impact on beneficiaries' access to and engagement in treatment. MCO and provider respondents in states that either updated or added new patient placement criteria or UM processes shared a mixture of negative and positive perceptions of impacts on beneficiaries' access to and engagement in treatment.

> *"The change that happened was really at the operational level, which [the state] had a fairly smooth transition to. There was a lot of documentation, but you were able to do it, pretty much did it on your own without a lot of help from anybody. There isn't really any impact on the patients throughout this."*
>
> -Provider respondent

Provider respondents in many states highlighted that the patient placement assessment and UM processes limited beneficiaries' access to care by restricting treatment options, and in some instances, according to providers, rationing care. Provider respondents also highlighted that the prior authorization processes sometimes delayed beneficiaries' access to care and treatment. One provider shared, *"the chances of you losing the patient and their interest in treatment [while you wait for prior authorization to come through] just grows because you have a very small window to engage them in treatment when they present and say that they're ready. I mean, the chances of them staying in the most perfect setting is small, but then staying with any barriers, it gets worse and worse. Any barriers, especially in those first few months of treatment, specifically the first week, it just triples how hard our jobs are."* Further, for hard-to-reach beneficiaries or those with HRSNs, such as homelessness, delays in obtaining care and treatment because of prior authorization processes further impeded their access to appropriate care.

Provider respondents in a few states highlighted that ASAM criteria did not fully account for HRSNs or recovery or treatment history. As a result, some beneficiaries were assessed to need low levels of care (such as outpatient) even though their personal background such as their lack of housing or other HRSNs might make a higher LOC (like residential) more appropriate.[18] As one provider respondent shared, "we've always worked hard and we're proud of referring [a homeless] client to a better place in housing. They have long-term sobriety under their belt, but no more can we do that. Now we might have to turn them away [from residential treatment] because if they're not given the authorization, they have to leave within 48 hours. The shelters are full, and to us, it's just horrifying what is going to happen with the hard rollout."

Provider respondents in several states commented that the patient assessment tool supported their ability to discuss treatment recommendations with beneficiaries. Previously, beneficiaries were not always given explanations about why they were placed in a

[16] KFF. (2021). *Medicaid emergency authority tracker: Approved state actions to address COVID-19*. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/

[17] CMS. (2022, October [updated]). *COVID-19 emergency declaration blanket waivers for health care providers*. https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

[18] Although ASAM dimension 6 focuses on living situation and housing needs, beneficiary responses to questions in this dimension do not outweigh the needs or LOC identified through the other dimensions.

certain treatment level. These provider respondents said they could use the ASAM tool and assessment results to guide discussions with beneficiaries about the LOC the tool recommended, the LOC the provider recommended, and reasons for any discrepancy between the two. These discussions helped providers engage beneficiaries in their care and treatment. As one provider respondent explained, *"If you use the leveling tool and if you use it correctly, then you can have a good clinical conversation around why you don't want to go to the level of care that was indicated and all of those kinds of things…. So I think it's a clinical impact more than anything."*

MCO and provider respondents in some states shared that the patient placement and UM processes helped beneficiaries obtain more appropriate care. Specifically, provider respondents indicated that the assessment questions and identifying the LOC that coincided with the beneficiaries' needs led to more appropriate care decisions and treatment paths for beneficiaries. One MCO respondent shared, *"[The ASAM assessment] really did do a good job of getting members in the level of care and also … held those levels of care to a higher standard. We had a little better understanding of what the members were getting or at least some expectations."*

MCO respondents also shared perceptions that patient placement criteria and UM had some positive impacts on beneficiaries' access to and engagement in care and treatment, although they did not have evidence to support this. MCO respondents in many states perceived that the patient placement assessment increased providers' awareness of the different LOCs. Further, states' internal metrics such as bed availability and occupancy at residential facilities helped inform providers about care and treatment availability. MCO respondents indicated this provider awareness improved beneficiaries' access to and quality of care by increasing the likelihood a patient would be placed in the appropriate LOC.

Conclusions

This report highlights the actions managed care and SUD provider organizations in 10 states took to implement widespread use of evidence-based, SUD-specific patient placement criteria and make accompanying changes in UM processes to achieve Milestone 2 of section 1115 SUD demonstrations. MCO and provider respondents from most of these states reported some experience using patient assessment tools and familiarity with UM processes before their states' demonstrations. These respondents leveraged their experiences, and meeting Milestone 2 required minimal changes for their organizations. MCO and provider respondents from four states did not have prior experience conducting patient placement assessments and had to develop processes and train providers to conduct them.

Provider education was critical to implementing Milestone 2. Providers needed to develop new expertise to implement SUD-specific multidimensional assessments and to navigate often complex UM processes. Even among providers who were familiar with or had used patient placement assessment criteria before their state's demonstration, some still faced a learning curve to meet MCO assessment requirements and provide satisfactory UM justifications. MCO respondents in nearly all states recognized the importance of provider education and, therefore, put considerable time and resources into it. Both provider organizations and MCOs hired staff to help providers learn about the new processes and reduce the learning curve.

Providers and MCOs had mixed sentiments about the changes in patient placement criteria and UM. Some respondents perceived the patient placement criteria as inflexible because they did not fully account for important factors such as beneficiaries' HRSNs or previous treatment and recovery experiences. Further, some providers shared that the patient placement criteria restricted their autonomy and ability to use their clinical judgement. Also, the patient assessment process along with UM created administrative burdens for MCOs and providers. Yet, MCO and provider respondents in some states shared that the patient placement and UM processes helped beneficiaries obtain more appropriate care.

The implications of placement assessment and UM processes for beneficiaries were also mixed. Some MCO and provider respondents described these as time-consuming processes that delayed beneficiaries' treatment. Other providers and MCOs perceived improvements in beneficiary access to appropriate care and engagement in treatment. Although providers and MCOs did not offer evidence of improvements, if borne out, they offer a promise of downstream savings through reductions in unnecessary or inappropriate treatment and better outcomes.

This rapid cycle report highlights the changes managed care and provider organizations made to address Milestone 2 of the section 1115 SUD demonstrations and the challenges that arose during implementation. Demonstration impacts may vary among states based on the extent and nature of challenges states experienced. The findings from these interviews may help to contextualize state-specific results from the impact analysis and meta-analysis or may support operationalization of new variables for those analyses.

Authors and Acknowledgments

This rapid cycle report was authored by Rebecca Perry, MSc; Rose Feinberg, MPH; Madeline Britvec, MSPH; Donna Spencer, PhD; Heather Kane, PhD; Susan Haber, ScD; and Anupa Bir, ScD. The authors would like to express appreciation to participating MCO and provider organizations for their time and their informed perspectives. The authors acknowledge Nathan Yates for editorial assistance. The authors also acknowledge the contribution of CMS staff who reviewed drafts of this report: Kirsten Beronio, Danielle Daly, Teresa DeCaro, Allen Ma, and Deborah Steinbach.

The Federal Meta-Analysis Support Contract

In 2018, the Centers for Medicare & Medicaid Services (CMS) commissioned the Federal Meta-Analysis Support contract (HHSM-500-2014-00037I) to learn from each Medicaid section 1115 demonstration and the groups of such demonstrations with similar features. Under this contract, RTI International is conducting meta-evaluations of selected groups of Medicaid section 1115 demonstrations.

Rapid cycle reporting is central to the Federal Meta-Analysis Support contract, providing CMS with timely, practical findings, and supporting dissemination of findings to key stakeholder audiences. This report is one of several rapid cycle reports prepared by RTI International under the contract.

Appendix A: Data, Methods, and Limitations

Findings in this report are based on interviews conducted by RTI International between June and October 2022. Key Medicaid MCO and provider informants in 10 states with SUD demonstrations participated in the interviews. These states were Idaho, Kentucky, Massachusetts, Michigan, New Jersey, New Mexico, North Carolina, Virginia, West Virginia, and the District of Columbia.[19] Selected states had at least two years of demonstration experience as of July 2022 and expanded or added coverage for residential care for SUD and/or added or updated their patient placement criteria or policies related to care coordination under the demonstrations. To identify potential respondents, we asked state Medicaid officials to share contact information for organizations contracted to manage a Medicaid population (i.e., MCOs and accountable care organizations), other organizations responsible for managing SUD provider networks or access to SUD services for Medicaid beneficiaries (e.g., PIHPs), and Medicaid provider organizations offering residential and nonresidential SUD services. We conducted up to 8 interviews in each state, totaling 70 interviews with representatives of 33 MCOs or other organizations responsible for managing SUD care (herein collectively referred to as "MCOs") and 37 SUD provider organizations (9 offering residential services, 11 nonresidential services, and 17 both residential and nonresidential services). We interviewed MCOs and provider organizations that represented different regions of the state and both urban and rural geographic areas. We targeted provider organizations that were operating in the state prior to the demonstrations and could compare delivery of SUD services before and after the implementation of the demonstrations.

We developed two semi-structured interview protocols, one for interviews with MCOs and one for interviews with SUD provider organizations. The protocols covered operational and administrative changes made in response to state changes under the demonstration in (1) Medicaid coverage, billing, and reimbursement (particularly for residential care); (2) patient placement criteria and UR; and (3) care coordination. The protocols also included questions about implementation challenges and facilitators and perceived impacts of the demonstrations on beneficiaries' access to care, beneficiaries' engagement and retention in SUD treatment, and health disparities in SUD treatment. Interviews were 60 minutes in length.

Interviews were audio recorded (with respondent permission) and transcribed. We analyzed the transcripts using NVivo 12.0. The initial analysis phase entailed a deductive coding process with prescribed codes for topics that aligned with the interview protocol. After this initial phase, the analysis team initiated an inductive coding process to identify and synthesize common changes organizations made, challenges to implementation, and perceived impacts on beneficiaries across states. We held regular coding reviews and debriefings for quality control purposes.

In the report, we use quantifying language (e.g., "all states," "some respondents") to give readers a sense of the number of respondents who mentioned a topic during an interview and therefore the prevalence of topics that respondents raised or addressed. We do not provide exact counts of respondents who mentioned a topic because the interviews were semi-structured in nature. Unlike the case of a structured survey with identical questions and response sets, we cannot conclude from semi-structured interviews that a particular topic was or was not relevant or meaningful to respondents who did not mention a particular topic.

This analysis has several limitations. First, we conducted interviews in 10 of 34 states with an approved section 1115 SUD demonstration. Findings may not represent experiences in the states implementing demonstrations that were not included. Second, our interviews did not necessarily include all MCOs or other organizations responsible for managing SUD care for Medicaid beneficiaries and included a convenience sample of Medicaid SUD provider organizations in each state. The perceptions and experiences of the respondents may not represent those of other organizations in the state. Finally, states had ongoing initiatives to address substance misuse unrelated to the demonstrations, making it difficult in some cases to attribute changes and impacts to the demonstrations. In some cases, MCO and provider respondents were not aware of the section 1115 SUD demonstrations, compounding difficulties attributing changes to the demonstrations.

[19] For brevity, we refer to states and the District of Columbia as "states."